# BUREAU OF QUALITY ASSURANCE

**PROGRAM REVIEW FOR**

## Thompson Academy

**Youth Services International/CSC Inc.**
**1150 Hibiscus Drive**
**Pembroke Pines, Florida 33025-4552**

***Review Date: October 25-29, 2004***

This review focused on the performance of the program concerning 13 standards, which covered such areas as Program Management, Living Environment, Case Management, Food Services, Mental Health & Substance Abuse, Program Security and many other functions. Performance indicators, used to measure each standard, were rated using the ten-point scale below, with 9 representing the highest performance possible.

| | | | |
|---|---|---|---|
| Superior Performance | 7 | 8 | 9 |
| Satisfactory Performance | 4 | 5 | 6 |
| Partial Performance | 1 | 2 | 3 |
| Non-Performance | | 0 | |

The review team used the following definitions of the above performance levels as a guide when rating performance indicators:

Superior Performance: The program is exceeding all elements required in the particular indicator with either an innovative approach or an exceptional, program-wide dedication to performance that is readily apparent. There is evidence of very few, if any, exceptions to this.

Satisfactory Performance: All of the requirements of the indicator are met almost all of the time. While the items, elements or actions necessary to accomplish the indicator are prevailing practice, minor exceptions may occur occasionally.

Partial Performance: Not all of the elements of the indicator are being accomplished or there are frequent exceptions to accomplishing the items, elements, or actions required to satisfy the requirements of the indicator. While there may be a policy in place, many staff are unaware of it or there is no policy or procedure in place although staff generally are accomplishing the indicator.

Non-Performance: The items, elements, or actions necessary to accomplish the indicator are missing or are done so poorly that they do not contribute to the accomplishment of the indicator or the overall standard.

Some indicators pertain to issues for which the program is either accomplishing or not accomplishing the function according to policy. These are compliance indicators and are rated according to the guide below.

| | |
|---|---|
| Full Compliance | 2 |
| Substantial Compliance | 1 |
| Non-Compliance | 0 |

The review team used the following definitions as a guide when rating compliance indicators:

Full Compliance: The program's policy, procedures and practice are in accordance with DJJ policy all of the time. (No exceptions).

Substantial Compliance: The program's policy, procedures and practice are in accordance with DJJ policy. All of the requirements for the indicator have been met with only minor exceptions.

Non-Compliance: The program's policy, procedures and practice are not in accordance with DJJ policy and/or there are numerous exceptions to the requirements of the indicator.

This report summarizes indicators that were rated superior, satisfactory, partial, non-performance or non-compliance and will not provide specific information on indicators, which were rated in the compliance range. Compliance and priority indicators are marked with a C and P respectively. (Numerical scores for individual indicators can be found in Appendix 1 of this report. For the overall program and compliance ratings, please refer to the attached Performance Profile.)

## EXTERNAL CONTROL FACTORS

Factors that may seriously impair a program's ability to perform, but which are beyond its control, are identified as external control factors. These factors, and the degree to which they influence a program's performance rating on a standard, are identified as a part of the quality assurance process and are noted below.

Subsequent to assuming management of the facility and staff on January 5, 2004, the program has experienced high personnel turnover from those previous employees.

## CRITICAL CONCERNS

Three staff were hired prior to receiving preliminary background screening approvals from the Background Screening Unit. Three other promoted staff did not have rescreenings documented in the files.

A review of a sample of 12 from 40 incidents filed revealed one A list and two B list incidents were not reported within the required timeframe. An additional B list incident did not list the time reported.

One of the 20 files reviewed contained a Massachusetts Youth Screening Instrument, Version Two (MAYSI-2) completed according to the indicator at admission. None of the files documented youth were placed on constant supervision until the MAYSI-2 was completed or an applicable assessment could determine the youth's mental health or substance abuse risk.

## STANDARD ONE: PROGRAM MANAGEMENT

**Overview:**

A facility administrator manages the program using a leadership team consisting of an assistant facility administrator (AFA), case management supervisor, clinical director, business manager, accounts payable clerk, administrative assistant, QA/training coordinator, lead nurse, maintenance supervisor, and a representative from the school system. The AFA has immediate supervision for the unit managers and operational aspects of the program. The facility was contracted for 112 beds, but the Department issued a contract amendment capping the number of youth at 80 until the facility and the program receive material, personnel and certification upgrades.

**1.01 The program has a written program description and mission statement that is generally understood by program staff. The written program description includes the program's mission, treatment approaches and desired outcomes and reflects a restorative justice philosophy. The mission statement of the program or parent agency encompasses the mission of the Department of Juvenile Justice.** **Full Compliance**

**C**

**1.02 The program director works in concert with the program's management team to identify, plan, and implement program improvement initiatives. Initiatives include identification of the persons responsible and target dates for completion. Progress is assessed and documented every six months.** **Satisfactory**

The program documented in March 2004 the inauguration of a direct care staff committee to draft the quality improvement initiatives and report to the Leadership. Minutes document discussion and adoption of eight initiatives in April 2004. The review of one initiative was documented September 7, 2004. Initiatives included the responsible staff assigned and projected date of completion. The review documented the progress of initiatives.

**1.03 Deleted.** **NA**

**1.04 The program director is actively involved in the community and has established a community advisory board or community support group. The group is composed of members from the community and serves as a link between the program and the community. (Refer to the key indicator for additional requirements)** **Satisfactory**

The program documented the recruitment of and two monthly meetings of the Community Advisory Board. The Board consists of members representing government administration, Office of the Public Defender, and the clergy. The program did not have a designated victim advocate.

**1.05 The program director conducts a monthly staff meeting that includes all supervisors and key program staff; i.e., maintenance, healthcare, educators, and treatment leaders. All supervisors will meet at least monthly with their respective staff. The director maintains copies of the agendas and minutes for each of the meetings.** **Superior**

The director conducts leadership meetings twice weekly, one formal, and one informal meeting. The formal meeting was documented by agenda, minutes and sign-in sheets and the informal meeting by sign-in sheets and minutes expanded from an informal agenda. These leadership meetings were consistently documented for most weeks since the program began operation. The review team attended a meeting, which was well conducted, persons were held accountable and issues resolved. Minutes documented meetings with all supervisors weekly with the AFA. Shift supervisors meet prior to each shift with all staff assigned to the shift. The program documented all staff meetings monthly in the last three months. Meetings are designed to allow half the staff to attend a meeting at 2-3 pm and 3-4 pm to facilitate 3-11

staff to attend the first meeting and 7-3 staff to attend the second meeting. Night staff are required to attend one of the meetings. Minutes, agenda and sign-in sheets documented these meetings.

**1.06 The program has facility operating procedures that are reviewed annually by the Chief Executive Officer (CEO), or their designee, or the program director, updated as needed and made available to all staff and volunteers. The procedures provide staff and volunteers a detailed, step-by-step description of the sequence of activities necessary to carry out a policy. Each original and revised facility operating procedure is signed by the CEO or, their designee or their program director and annual reviews are documented in writing.** **Satisfactory**

The program documented current facility operating procedures, all of which were signed by the responsible parties within the past year. Most of the policies addressed the indicators. However, the procedures were generally brief and lacked detail.

**1.07 Written policy, procedure, and practice document that: all allegations of child abuse or suspected child abuse are immediately reported first to the Florida Abuse Hotline and then second to the Department of Juvenile Justice Office of the Inspector General (OIG) hotline. Law enforcement reports directly and only to the (OIG) Hotline. Youth eighteen years of age or older report alleged abuse to DJJ IG's incident/complaint hotline. Youth have unimpeded access to self-report alleged abuse. (Refer to the key indicator for additional requirements.)** **Full Compliance**

**C/P**

**1.08 The program director or designee attempts to recruit volunteers from the community to donate their time and effort to enhance the activities of the program. All recruitment efforts are documented.** **Satisfactory**

The program documented some of their efforts to recruit volunteers with letters and electronic mail. The program documented four volunteers from the faith community. All were background screened, had received training in confidentiality and program procedures and had a signed job description. The volunteer who had accepted responsibility for recruiting volunteers also organized an initiative to provide a free meal for a celebration at the program.

**1.09 The program has written position descriptions, performance objectives, performance standards, or job duties for all positions, including volunteers. Performance reviews are conducted annually and signed by the supervisor and employee. Staff are provided a copy of their position description.** **Substantial Compliance**

**C** Reviews of files found 18 of 20 with a current, signed job description; two recently promoted staff did not have an updated job description for the new position. All staff surveyed stated they had received a copy of their job description.

**1.10 Written policy, procedure, and practice document: behavioral expectations for all staff that encourages staff to model social skills and forbids the use of profanity, threats, and intimidation. (Refer to the key indictor for additional requirements.)** **Partial**

Documentation reviewed found the program consequenced several staff for issues such as tardiness, failure to show for work, failure to attend training, failure to attend scheduled meetings, failure to perform according to expectations, horse playing and insubordination. Types of discipline imposed included oral warning, written warning, suspension and terminations. However, the team observed staff wearing cutoffs, sloppy dress, low hanging trousers, which reflected on the youth dress code. In addition, youth and staff reported in surveys of staff resorting to using cursing language when directing youth.

**1.11 The program director or designee actively participates with law enforcement agencies and/or other criminal justice agencies; i.e., Florida Department of Juvenile Justice, Florida Department of Corrections, and Florida Department of Law Enforcement and school districts knowledgeable of criminal street gangs to coordinate sharing of information for Florida's Gang Intelligence System (FGIS). (Refer to the key indicator for additional requirements.)** **Partial**

The program has identified a staff member who compiles information on gangs and has conducted a gang information training for all staff. The designated staff has not connected with a local gang intelligence unit, and no documentation of efforts to find the unit were produced. One youth with a history of gang involvement was not identified at intake, assessment, or treatment planning.

**1.12 The program director or designee conducts a monthly JJIS audit and reports discrepancies to the Chief Commitment Manager.** **Full Compliance**

**C**

**1.13 Written policy, procedure and practice document that a preliminary background screening has been conducted on all employees and volunteers, in accordance with Chapter 985.407, Florida Statutes and the department's policy. (Refer to the key indicator for additional requirements.)** **Non-Compliance**

**C/P** Three staff were hired prior to receiving preliminary background screening approvals from the Background Screening Unit. Three other staff were promoted but rescreenings were not documented in the files.

**1.14 Written policy, procedure and practice document that the program complies with the department's policy on incident reporting. Incident reports are properly completed and documented within the required timeframes. The program maintains a separate file of all incidents.** **Non-Compliance**

**C/P** A review of a sample of 12 from 40 incidents filed revealed one A list and two B list incidents not reported within the required timeframe. One additional B list incident report did not include the time reported.

**1.15 Deleted** **NA**

**External Control Factors**

None.

## STANDARD TWO: ADMISSION AND ORIENTATION PROCESS

**Overview:**

The program employs a case management supervisor and four case managers who perform most of the intake responsibilities. Each case manager is responsible for a maximum caseload of 25, with the supervisor taking transition cases and/or those in excess of 100. The intake interview is conducted by the case manager plus all the key personnel together in a conference room in the administration building. One intake interview observed included all the key personnel in the conference room with the new youth in what appeared to be a group interview. The case manager is then responsible to assemble the case record and ensure all the notifications are completed. The current case management supervisor is the third person to occupy that position since January 2004.

**2.01 Written policy, procedure, and practice specify that the program maintain official individual management record for each youth. (Refer to the key indicator for additional requirements.)** **Satisfactory**

The written policy and procedure address all areas of the indicator. All 20 individual management records had very good detailed information on the admission card with a good quality photograph of the youth. Most other parts of the indicator were in place. There was no documentation the program director or designee reviewed case records monthly.

**2.02 Written policy, procedure, and practice provide that all youth are classified upon admission to determine the most appropriate placement and sleeping arrangements and to increase staff awareness of classification issues. (Refer to the key indicator for additional requirements.)** **Satisfactory**

The written policy and procedure address all areas of the indicator. The program classification form includes all the required areas. File reviews reveal most forms were filled out completely, including a summary of findings and dorm and room assignment. The program also has a six-color coded alert board in each dorm office including a photo of each youth and alert categories such as suicide, Baker Act, flight risk, bed rest, detention or 24-hour observation. However, the classification form only includes three alert categories that are not in consonance with the dorm alert categories.

**2.03 Written policy, procedure, and practice document that the program has a process in place to review a juvenile's commitment packet upon admission and identify any items that may be missing. (Refer to the key indicator for additional requirements.)** **Satisfactory**

The written policy and procedure address all areas of the indicator. The program documented efforts by telephone and facsimile transmission to obtain missing documents in commitment packets. Nineteen of 20 files reviewed contained a Jimmy Ryce screening instrument. No documentation was found of efforts to obtain the missing screening form.

**2.04 Written policy, procedure, and practice document that parents/guardians are notified when a youth is admitted to the program. Within one day of youth's admission, program staff notify the youth's parents or guardians by telephone and staff must continue the process until contact is made. Within two days, excluding weekends and holidays, a personal letter, which is signed by the program director, is sent to parents or guardians. (Refer to the key indicator for additional requirements.)** **Satisfactory**

The written policy and procedure address all areas of the indicator. All 20 files documented parental notification within the required timeframe. The parental letter includes all the required information. Documentation supporting the phone call was found in the chronological record.

**2.05 Written policy, procedure, and practice document that the program director or designee: notifies the committing court of each youth's admission in writing within 5 working days of admission, written notification includes the name of the committing judge on the notification documentation and provides a copy of the letter sent to the DJJ juvenile probation officer or designated conditional release JPO if known.** **Full Compliance**

**C**

**2.06 Written policy, procedure, and practice document that orientation to the program begins within 24 hours of admission. (Refer to the key indicator for additional requirements.)** **Satisfactory**

The written policy and procedure address all areas of the indicator. All 20 files documented the orientation process is begun within 24 hours of admission and covers all areas of the indicator. An observation of one admission confirmed the youth meets the key staff involved in his treatment.

**2.07 Written policy, procedure, and practice ensure Departmental requirements to conduct a strip search upon admission are followed. (Refer to the key indicator for special** **Full Compliance**

**requirements by program model.)**

**C**

**2.08 Written policy, procedures and practices govern the control and safeguarding of personal property. Personal property retained at the program is itemized in a written list and secured at the program. The youth reviews and signs the list, acknowledging that it is correct. (Refer to the key indicator for special requirements)** **Full Compliance**

**C**

**External Control Factors**

None.

## STANDARD THREE: LIVING AND TREATMENT ENVIRONMENT

### Overview:

The program is on the campus of a former state mental hospital in seven aging buildings, situated around two recreation courtyards. The three residential units are arranged with two wings parallel to and on opposite ends of a central sub-control and adjacent nursing station and large group room. Each wing includes a shower area, commodes and sinks. Sleeping rooms utilize bunk beds and may have two, four or six sets of bunks. Each bunk appears to be assigned a respective footlocker. The cafeteria includes an adjacent kitchen with warming trays and serving line, refrigeration and freezer units and washing facilities, but no food preparation appliances or implements.

**3.01 The program, including the attached buildings and grounds, is clean, landscaped and well maintained. (Refer to the key indicator for special requirements by program model.)** **Satisfactory**

Fixtures in bathrooms were observed missing or damaged in all three living areas. The restrooms in one unit had showerheads missing and an inoperable toilet; another unit was missing a faucet knob and the water temperature not warm; and a third unit was missing a sink, showerhead and shower knob. Monitoring reports document this discrepancy in July and the program appeared to be in the same condition. The cafeteria had noticeable holes in the wall that were being repaired in the latter part of the review week. The team observed sporks and other debris lying in the dirt around the courtyard perimeter.

**3.02 All sleeping quarters have adequate lighting for any tasks that needs to be performed there, bed coverings and pillows are in good condition, and there is an individual bed for each youth. There are no extraneous cover, wire mesh, paper, cardboard, etc. that are to be installed over glass, windows, vents or sprinkler head in the sleeping areas. Youth are permitted to personalize their room. (Refer to the key indicator for special requirements by program model.)** **Satisfactory**

The written policy and procedure address all areas of the indicator. Youth are allowed to personalize their footlocker inside the lid. Some youth lockers were personalized.

**3.03 The program has designated space for academic activities, individual counseling, large and small group meetings, visitation, meals, and indoor/outdoor recreation.** **Satisfactory**

The program has designated and adequate space for academic activities, counseling, group and individual counseling, visitation, meals and recreation. Youth were observed eating some meals as a normal course of action in the module on the floor.

**3.04 There exists a daily master schedule which is posted in areas accessible to youth and is substantially followed. (Refer to the key indicator for additional requirements.)** **Substantial Compliance**

**C** The master schedule posted throughout the buildings was found accessible to youth. Most of the elements of the indicator were represented on the schedule. The schedule utilized during school holidays did not offer structured educational activities.

**3.05 Written policy, procedures and practice document that all youth are given the opportunity to participate in faith-based services. Participation in religious services is voluntary and non-punitive activities are provided for youth who don't participate.** **Satisfactory**

The written policy and procedure address all areas of the indicator. The master schedule does not reflect the opportunities for faith-based programming. Youth surveys state and informal interviews confirm voluntary faith based initiatives take place several times weekly recently, though this practice was not consistent throughout the review period. .

**3.06 Written policy, procedures and practices for personal hygiene document that youth are provided articles for personal grooming, such as toothpaste, toothbrush, soap, comb, toilet paper, sanitary products, and deodorant. (Refer to key indicator for additional requirements.)** **Satisfactory**

The written policy and procedure address all areas of the indicator. Observations of the morning and evening routine confirm youth have several opportunities to care for personal hygiene and the materials are provided. Youth appeared to be well groomed with close cut fingernails.

**3.07 Youth are provided with clean bed linens at least once weekly and towels at least daily. Clean blankets are provided as appropriate to the season. (Refer to the key indicator for special requirements by program model.)** **Non-Compliance**

**C** Seven of 17 youth responding to the survey state they receive clean towels on a daily basis and 12 of them state they receive clean sheets at least once per week. Interviews with staff confirm that youth receive a clean towel and bed linens upon request. Inconsistencies with student surveys, individual interviews with youth and staff did not clarify conflicting answers regarding the process and policy.

**3.08 Written policy, procedure, and practice document that the program has a resident grievance process that allows youth to grieve, in writing, the actions of program staff or the youth's peers, or conditions or circumstances of care and treatment that are a violation of their rights. (Refer to the key indicator for additional requirements.)** **Non-Performance**

During the tour, the team did not observe grievance forms available to youth. Blank forms were maintained in the staff office with youth required to request one if needed. Several grievances were not documented as having been resolved. Grievance process rules were observed posted only in the cafeteria. The form is not clear regarding where the youth should write out the grievance. Staff gave inconsistent responses regarding the submission and resolution procedure.

**3.09 Visitation rules are posted at the visitors' entrance or provided to visitors upon entry. Written operational procedures and practice for visitation documentation. (Refer to the key indicator for additional requirements.)** **Satisfactory**

The visitation policy was observed posted in front of the building and in the visitation area. There was no documentation of searches of the visitation common area or frisk searches of youth following visitation. An approved visitor list was present for 40 of 80 youth. The program maintained a log for visitor sign-in, however sign-outs were inconsistently documented.

**3.10 Written policy, procedures and practice for correspondence documentation the program maintains an approved correspondence list for each youth (the list may be a list of individuals the youth can correspond with or a list of individuals the youth cannot** **Partial**

**correspond with). (Refer to key indicator for additional requirements.)**

The written policy and procedure address all areas of the indicator. The approved correspondence lists contained approved forms for 40 of the 80 youth in the program. No process was found to ensure youth do not contact their victim(s).

**3.11 Written policy, procedure, and practice for the use of the telephone documents the hours of telephone availability and procedures for receipt of telephone calls. (Refer to key indicator for additional requirements.)** **Partial**

The written policy and procedure address most areas of the indicator. The procedures did not detail procedures for receipt of phone calls, procedures to prevent victim contact, or for providing long distance calls for youth whose parents cannot accept collect calls. A phone log documented youth phone calls. Youth surveys state and interviews with youth and staff confirm the program allows regular phone contact with family members.

**3.12 Written policy, procedure, and practice document a dress code for youth. The dress code includes prohibition against pictures, logos, emblems, or writing that are sexually provocative or depict illegal activity, violence, gang affiliation, profanity or sexually provocative material on any article of clothing. Pants or shorts must be pulled to the waist level and be properly fastened as to not reveal underwear. Clothing and shoes are neat, clean, properly fitting and in good repair.** **Satisfactory**

The written policy and procedure address all areas of the indicator. Daily observations of youth revealed the program provides clothing and shoes that are generally serviceable and in good repair. Youth shoes were designed with Velcro straps. Some youth stated and staff confirmed they were wearing slides because the program had exhausted its reserve supply of shoes and were unable to issue the youth a replacement pair.

**External Control Factors**

None.

## STANDARD FOUR: CASE MANAGEMENT AND PERFORMANCE PLANNING

**Overview:**

The program employs a supervisor and four staff who perform all of the case management responsibilities. Case managers operate the treatment teams, record the findings and file all required reports and documentation. The case managers' offices are situated in the units, while the supervisor's office is in the administration building. The current case management supervisor is the third person to occupy that position since January 2004. Home Builders Institute (HBI), which is a nationally recognized program for adolescent youth, has begun to serve 10 youth within the last month prior to the review. HBI provides youth vocational, social and life skills training in the context of teaching primarily building skills.

**4.01 Written policy, procedure and practice document that the program establishes a multidisciplinary treatment team consisting of representatives from the various areas of treatment and direct care. (Refer to key indicator for additional requirements.)** **Partial**

Informal or formal treatment team case reviews are not being held within the required timeframes. Treatment team members do not consistently attend formal treatment team meeting every 30 days. Members do not provide any documentation if they are not attending. Three of 20 files reviewed did not have any formal or informal treatment team documentation. Eleven of 19 applicable files documented bi-weekly informal treatment team reviews. Eight of 19 applicable files documented monthly formal reviews. One of 19 applicable files reviewed documented all applicable members were present for treatment team.

**4.02 Written policy, procedure and practices document that the treatment team conducts an evaluation of the youth and family to determine treatment needs. (Refer to key indicator for additional requirements.)** **Partial**

The written policy and procedure address all areas of the indicator. Seven of 19 applicable files reviewed were not completed within the required timeframe and were not completed prior to the performance plan. Numerous files did not complete the sections regarding vocational, physical health, substance abuse or mental health. Only the youth and case manager signed the assessment/evaluation form. Several files reviewed had incomplete forms.

**4.03 Written policy, procedure, and practice document that the treatment team or admission staff review each youth's case file to determine if the youth has been DNA tested. Any youth in residential placement, who meets criteria for DNA testing and has not been tested, must submit to testing not less than forty-five days before release.** **Full Compliance**

**C**

**4.04 Written policy, procedures and practices document that the treatment team develops an individualized performance plan with each youth. The performance plan goals are written and prioritized by the treatment team. (Refer to the key indicator for additional requirements.)** **Partial**

**P** The written policy and procedure address all areas of the indicator. Fifteen of 19 applicable performance plans were completed outside of the required timeframe. There was no documentation the youth goals were developed and prioritized by the treatment team. Goals did not appear measurable. Only the youth and case manager develop the goals and sign them. Goals did not include targeted dates of completion, or if a goal was completed no documentation supported the event.

**4.05 The performance plan is distributed within 5 working days of completion to the youth, JPO, parent/guardians and Department of Children and families for youth jointly served by DJJ and DCF. The name of the persons copied and title is included on the transmittal letter.** **Non-Compliance**

**C** Three of 19 performance plans were distributed to all the required parties within the required timeframe. Some plans were not dated. Some plans were sent out as late as two or three months after the required timeframe. Several youth stated they did not receive a copy of their respective performance plan.

**4.06 Written policy, procedures and practice document that the treatment team makes on-going revisions to the performance plan. Revisions are made to reflect completed goals or target date changes or new goals, which are added based on the prioritized needs list or newly identified needs, and whenever a revision is in the best interest of the youth's rehabilitation and public safety.** **Non-Performance**

The written policy and procedure address all areas of the indicator. No documentation was found to support that the treatment team makes revisions to youth goals or that youth have completed goals. Ten of 17 youth responding to the survey said their goals have been revised. Staff stated they had not revised any goals in the performance plans reviewed.

**4.07 Written policy, procedures and practice document that a performance summary is completed every 30-calendar days following the signing of the performance plan. The performance summary addresses but are not limited to the following areas: the youth's status on their performance plan goals, the youth's academic status. (Refer to key indicator for additional requirements.)** **Partial**

The written policy and procedure address all areas of the indicator. Twelve of 18 applicable files reviewed documented late or no 30-day summaries sent within the required timeframe. Of those files with one or more summaries, 13 of 18 reviewed the youth's behavior and

progress in all the required areas. Informal interviews indicated several youth had not received regular performance summaries.

**4.08 Written policy, procedure, and practice document that the program provides services that teach youth the harmful consequences of their criminal behavior and focus on each youth's need to make reparation to victims and victimized communities.** **Partial**

The written policy and procedure address all areas of the indicator. The program has a very detailed curriculum. No documentation was found to verify that these services are being provided. Of 19 youth responding to the survey, 11 youth stated they had discussed victims of crime during group, while 13 stated that staff explained how criminal behavior affects victims.

**4.09 Written policy, procedure, and practice document that the program provides group work based on established group processes and principles that assists youth in identifying problems and gaining insights into the relationships between their attitudes and behavior. (Refer to key indicator for additional requirements.)** **Partial**

The written policy and procedure address all areas of the indicator. All 19 youth surveys document some kind of group discussion on a wide variety of topics. Nine youth stated group counseling was very helpful, while seven stated that it was somewhat helpful. However, the cursory documentation found in mental health files did not support the breadth of subjects youth stated they had experienced. Some youth files had very little documentation of group work.

**4.10 Written policy, procedure, and practice specify that the program promote family involvement to prepare the youth for return to the community. These services include access to family services and/or family treatment, as needed, conferences, and family outreach to address family reunification issues. (Refer to key indicator for additional requirements.)** **Satisfactory**

The written policy and procedure address all areas of the indicator. The program schedules visitation time twice on each Saturday and Sunday. Family members are required to call the case manager to sign-up for one of those scheduled times. Family members are notified by mail of policy and procedure and of the requirement to return an approved phone call, correspondence and visitation list. Documentation supported the written policy and procedures. Case files documented very few family conferences or family outreach efforts. Half of the documented requests for parental approvals received no response. The program did not document efforts of follow up requests for parental approvals for which there was no response.

**4.11 Written policy, procedure and practice document that youth are provided social and life skills training. Staff reinforce and model appropriate social skills.** **Partial**

The written policy and procedure address all areas of the indicator. All 19 youth surveys document some kind of group discussions on a wide variety of topics. However, documentation did not support the delivery of social and skill training stated by staff and youth. An overlay building trades vocational program began services several weeks prior to the review. Eight of 19 youth surveys state that staff use curse words when addressing the other youth.

**4.12 Written policy, procedure, and practice ensure statutory requirements are met whenever youth have access to the community and participate in off-site activities or are approved for a temporary release from the program. (Refer to key indicator for specific requirements by program model.)** **Satisfactory**

**P** The written policy and procedure address all areas of the indicator. The program has not allowed any youth access to the community since the program opened.

**4.13 Youth are recognized for their achievements.** **Satisfactory**

Youth work was observed posted in some areas of the program. One board was observed posted in a hallway with pictures of youth engaged in various activities. Schoolwork was posted in classrooms. Other youth work was observed posted in a unit.

**4.14 Written policy, procedure and practice documents the coordination of services including mental health and substance abuse services for youth served by the Department and the Department of Children and Families (DCF). (Refer to key indicator for additional requirements)** **Satisfactory**

The written policy and procedure address all areas of the indicator. Documentation in youth files support the program communicates with the Department of Children and Families (DCF) for applicable youth. Interviews with applicable youth confirm the DCF assigned worker communicates and visits with them and the program.

**External Control Factors**

None.

## STANDARD FIVE: MENTAL HEALTH AND SUBSTANCE ABUSE

**Overview:**

A licensed clinical director and a recently hired assistant director manage the seven mental health specialists. The mental health staff includes two licensed clinical psychologists, a licensed clinical social worker, two unlicensed clinical psychologists and four unlicensed masters level therapists. The program has an overlay contract to provide psychiatric services that include on-site visits by a psychiatrist and an advanced registered nurse practitioner (ARNP) to administer psychiatric evaluations and prescribe and monitor medications. Case managers are responsible to administer the screening instrument at admission and make the appropriate referral. Mental health staff perform initial mental health evaluations, prepare treatment plans for licensed professionals to review and sign, and conduct mental health and substance abuse group and individual therapy. The previous provider was subcontracted to provide mental health and substance abuse services through June 7, 2004. The program subsumed the mental health and substance abuse aspect of the program the second week of June 2004. Youth files reviewed were primarily drawn from the population admitted after the program began providing mental health and substance abuse services.

**5.01 Written operational procedures and practice document that all new admissions to the program are screened for substance abuse and mental health problems during the initial intake process. (Refer to key indicator for additional requirements.)** **Non-Performance**

**P** The written policy and procedure address all areas of the indicator. Only one of 20 files reviewed contained a Massachusetts Youth Screening Instrument, Version Two (MAYSI-2) completed at admission. The six most recent admissions from the sample included three that were not screened at admission. None of the 17 applicable youth were documented as being placed on constant supervision until the screening was completed. The program did not document referrals for 10 of 11 youth who had hits on the MAYSI-2. Only two of 11 youth with hits on the MAYSI-2 were documented as being placed on constant supervision until a further assessment could be completed. All suicide risk assessments in files addressed all elements of the indicator and were signed by a licensed clinician. However, none were completed within the required timeframe. A review of files revealed the program was using a brief biopsychosocial assessment as a screening instrument on the day of admission.

**5.02 Facilities with 100 or more beds have a designated mental health authority with responsibility for ensuring that mental health services are coordinated and implemented in the program. (Refer to key indicator for additional requirements.)** **Full Compliance**

**C**

**5.03 The program has a written plan for the delivery of mental health services to youths in need of such services. (Refer to key indicator for additional requirements.)** **Partial**

The written policy and procedure address most areas of the indicator. The current plan was revised September 9, 2004 for the second time since the program opened. The plan was revised when the program took over clinical services from the previous provider and in response to the requirement to obtain BHOS certification. The plan is a joint document including plans for delivery of mental health and substance abuse services. The policy states the plan will describe the method of ensuring services. However, the plan does not address the procedures for mental health treatment plan reviews, revisions/updates or monthly summaries and transition planning. Procedures addressing inclusion of goals in the performance plan were vague. The plan describes provision of monthly individual therapy sessions, group therapy five times weekly and provision for family, behavior and psycho-pharmacological therapies as needed. There was little or no evidence of mental health goals being included in the performance plans.

**5.04 The program has a written plan for the delivery of substance abuse services to youths in need of such services. (Refer to key indicator for additional requirements.)** **Partial**

The written policy and procedure address most areas of the indicator. The current plan was revised September 9, 2004 for the second time since the program opened. The plan was revised when the program took over clinical services from the previous provider and in response to the requirement to obtain BHOS certification. The plan is a joint document including plans for delivery of mental health and substance abuse services. The policy states the substance abuse treatment plan will describe the method of ensuring services. However, the plan does not address the procedures for providing prevention, intervention, substance abuse education, relapse prevention and provisions for inclusion of goals in the performance plan were vague. There was little or no evidence of substance abuse goals included in the performance plans.

**5.05 Practice documents that a comprehensive, "in-depth" mental health evaluation is done for all youth who indicate a mental health problem and need for further evaluation during the initial screening process or as indicated by behavior after admission to a facility/program. The comprehensive assessment, if indicated, is completed within thirty calendar days. (Refer to key indicator for additional requirements.)** **Partial**

The program provides a comprehensive mental health evaluation for all youth in the program, not just those who receive a hit on the screening instrument. All applicable 19 evaluations reviewed contained behavioral observations, mental health status exam, diagnostic impressions and recommendations. Most included identifying information, interview procedures administered and the reason for the evaluation. Thirteen of 19 evaluations did not include information from all the screening tools combining them into one. None of the evaluations included information from the psychiatric evaluation completed by the ARNP on all youth. The licensed professional signed 18 of 19 evaluations. Thirteen of 19 applicable files were completed within the required timeframe. Six of 19 applicable evaluations were not completed within the required timeframe without documentation of the reasons. One youth file documented the comprehensive evaluation completed 120 days after admission.

**5.06 Practice documents that a comprehensive substance abuse evaluation is done for all youth who indicate a substance abuse problem and need for further evaluation during the initial screening process or as indicated by behavior after admission to a facility/program. The comprehensive substance abuse assessment, if indicated, is completed within thirty calendar days. (Refer to key indicator for additional requirements.)** **Partial**

The program provides a comprehensive substance abuse evaluation, which serves as the substance abuse evaluation for all youth in the program. All applicable 19 evaluations reviewed contained behavioral observations, mental health status exam, diagnostic impressions and recommendations. Most included identifying information, interview procedures administered and the reason for the evaluation. Thirteen of 19 evaluations did not include information from all the screening tools combining them into one. None of the evaluations included information from the psychiatric evaluation completed by the ARNP on all youth. The licensed professional signed eighteen of 19 evaluations. Thirteen of 19 applicable files were completed within the required timeframe. Six of 19 applicable evaluations were not completed within the required timeframe without documentation of the reasons. One youth file documented the comprehensive evaluation completed 120 days after admission.

**5.07 The program can document that all youth who are receiving mental health treatment have a mental health treatment plan. (Refer to key indicator for additional requirements.)** **Partial**

Eight of 19 applicable files contained mental health treatment plans completed more than 15 days following completion of the comprehensive mental health evaluation. One file of a youth admitted in July did not contain a mental health treatment plan. Six plans were signed prior to completion of the comprehensive mental health evaluation. Four of the plans were completed 60 to 83 days after admission. All of these youth were receiving mental health services without a treatment plan in place. Half of the youth files documented in the case managers section some parental contact in the preparation of the plan. However, none of the mental health treatment plans included evidence of this information in the plan or of a signature from the parent or guardian endorsing the plan. Mental health treatment plans included the diagnosis, brief statement concerning the youth and family strengths, several goals with target dates, intervention/strategies, and responsibilities. Clinical supervision of non-licensed clinicians was documented occasionally in August and September, and regularly in October. Of 19 youth surveyed, 16 reported they meet with a counselor, of which nine said the counseling was very helpful, four said the counseling was somewhat helpful, three said the counseling was not helpful.

**5.08 The program can document that all youth who are receiving substance abuse treatment have a substance abuse treatment plan. (Refer to key indicator for additional requirements.)** **Partial**

Eight of 19 applicable files contained substance abuse treatment plans completed more than 15 days following completion of the comprehensive substance abuse evaluation. One youth admitted in July did not contain a substance abuse treatment plan on file. Six plans were signed prior to completion of the comprehensive evaluation. Four of the plans were completed 60 to 83 days after admission. Relapse prevention strategies and behavior therapy were not addressed in most substance abuse treatment plans. Half of the youth files documented in the case managers section some parental contact in the preparation of the plan. However, none of the substance abuse treatment plans included evidence of this information in the plan or of a signature from the parent or guardian endorsing the plan. Substance abuse treatment plans included the diagnosis, brief statement concerning the youth and family strengths, several goals with target dates, intervention/strategies, and responsibilities. Clinical supervision of non-licensed clinicians was documented occasionally in August and September, and regularly in October. Of 19 youth surveyed, 16 reported they meet with a counselor, of which nine said the counseling was very helpful, four said the counseling was somewhat helpful, three said the counseling was not helpful.

**5.09 The program has a written suicide prevention plan that details suicide prevention procedures. The plan is reviewed annually by the program director and mental health professional and updated as needed. (Refer to key indicator for additional** **Partial**

**requirements.)**

**P** The suicide prevention plan addresses all elements of the indicator, but the practice documented was not consistent with the plan. The practice documented MAYSI-2 screenings and any necessary subsequent suicide risk assessments did not follow the procedures outlined in the plan. Several cases documented youth with suicidal ideations who were screened, evaluated and placed on precautionary observations. However, referrals to the mental health professional when suicidal ideations occurred were not documented and the flow of communication between direct care staff and therapist was not clear. There was little documentation youth were placed on constant supervision until seen by the therapist.

**5.10 The written suicide prevention plan documents procedures for use of Precautionary Observation. The use of Precautionary Observation shall not restrict a youth to his sleeping room or cell (locked or unlocked) and must not include a confinement room. (The youth is, as much as possible, involved in regular programming, education, recreation, and dayroom activities.) (Refer to the key indicator for additional requirements.)** **Partial**

**P** Authorization for precautionary observation was inconsistently documented. Several precautionary observation logs were incomplete and days were missing from the packet. Ten of 11 files with hits either did not have any precautionary logs or days were missing from the file. Some logs documented by two different staff about the same hour and day reported incongruous behavior.

**5.11 Written policy, procedure and practice document that the temporary placement of a potentially suicidal youth in a secure observation room is done only when the youth is demonstrating suicide risk behaviors, which threaten his or her safety. (Refer to the key indicator for additional requirements.)** **NA**

The program does not practice the use of secure observation.

**5.12 The program has a written mental health and substance abuse crisis intervention and emergency response plan. The plan is reviewed annually by the program director and updated as needed. (Refer to the key indicator for additional requirements.)** **Satisfactory**

The crisis intervention plan addresses all areas of the indicator. The program generally followed the plan when youth demonstrated the need for transportation to a crisis unit for treatment. Documentation of all the steps taken in acquiring treatment was not consistently clear.

**External Control Factors**

None.

## STANDARD SIX: BEHAVIOR MANAGEMENT

**Overview:**

The core of the behavior management system is a cognitive based model placing emphasis on a positive peer environment along with education. The system has privileges and rewards based on a four level system in which youth on level one have basic rights and youth on level four have the greatest number of privileges. Direct care staff award points, all staff write-up youth behaviors, and case management staff keep track of the totals. The treatment team reviews points and behavior write-ups. Staff documents their individual involvement in PAR related incidents, while supervisory staff review and file the documentation.

**6.01 Written policy, procedure and practice document a behavior management system designed to foster compliance with the program's rules and teach youth alternative pro-social methods of dealing with problems. (Refer to the key indicator for additional** **Satisfactory**

**requirements.)**

The written policy and procedure address all areas of the indicator. The provider sent personnel from another program to train staff on the behavior management system in July 2004 and implement in August. The process described to the reviewers was not practiced consistently during the review week. The written system contains language that appears the group may experience consequences for a few youth misbehaviors. Ten of 11 staff surveyed feel the behavior management system is effective.

**6.02 Written policy, procedure and practice document that consequences and sanctions for program rule violations are directly related to the seriousness of the inappropriate behavior exhibited and are done on an individual basis, prohibit group punishment and requires documentation of prior supervisory or treatment team review of disciplines which result in privilege suspension, room restriction, program restriction, level drop, etc.** **Partial**

The written policy and procedure address all areas of the indicator. Eight of 18 youth responding to the survey stated they felt level drops, point deductions and other consequences were not given on an individual basis. Seven of 18 youth responding to the survey stated staff confront misbehaving youth, six stated staff give fair consequences, and four stated staff give reasons for the consequences. Seven youth stated staff does not do any of those actions. The program lists major and minor consequences. However, it does not detail which consequences could result from particular offenses. In addition, treatment team review of major consequences was inconsistently documented.

**6.03 Written policy, procedure and practice document that privilege suspension, room restriction, disciplinary confinement, secure observation and placement in a behavior management unit does not deny youth regular meals, snacks, clothing, sleep, school, exercise, physical & mental health care services, correspondence privileges, or contact with parents/guardians, juvenile probation officer, attorney of record, or clergy.** **Full Compliance**

**C/P**

**6.04 Written policy, procedure and practice provide that no juvenile or group of juveniles are given authority to impose disciplinary sanctions over other juveniles.** **Full Compliance**

**C**

**6.05 Written policy, procedure and practice provide that restricting a youth's participation in the program's routine activities through the use of room restriction is consistent. Room restriction must not be used for a youth who is out of control or suicidal and a supervisor must give prior approval for the use of room restriction. (Refer to the key indicator for additional requirements.)** **Partial**

The written policy and procedure address all areas of the indicator. Staff stated and written procedure indicated the program does not practice room restriction. However, the policy and procedures include individual Intensive Supervision and Support (ISS) and Unit ISS, both of which require the approval of a supervisor. A portion of the ISS is the requirement for "early rack" or an intervention that restricts the youth movement to his room and limits participation in the normal schedule of activities. Youth individual interviews reported the practice of being sent to their room, usually following the evening meal, for behavioral consequences and staff performing 10-minute checks was a regular occurrence. Staff admitted the practice is part of the behavioral system. Some documented 10-minute checks for youth restricted to the room beginning at 7:00 pm were observed maintained along with the regular nightly 10-minute checks. The ISS incidents documented were not completed consistently, include the beginning or end time of the restriction or include a discussion every 30 minutes. Youth interviews confirm the door was consistently left open during the "early rack" times. No practice of Unit ISS was documented.

**6.06 Written policy, procedure, and practice provide that disciplinary confinement is used only after all other less restrictive interventions have been attempted or are deemed inappropriate. (Refer to the key indicator for specific requirements.)** **NA**

The program does not practice the use of disciplinary confinement; therefore, the indicator was not rated.

**6.07 Written policy, procedure and practice document that the temporary placement of a youth in secure observation is done only when a youth's rapid and sudden onset of dangerous behavior presents an immediate and serious physical threat to his/her safety, the safety of other youth, or to the program. (Refer to the key indicator for additional requirements.)** **NA**

The program does not practice the use of secure observation; therefore, the indicator was not rated.

**6.08 Written policy, procedure and practice provide that if a behavior management unit is implemented, it is a component of the behavior management system to house those youth whose inappropriate behavior threatens the orderly management of the program. (Refer to the key indicator for specific requirements.)** **NA**

The program does not operate a behavior management unit; therefore, the indicator was not rated.

**6.09 Written policy, procedure and practice for the use of restraints document that mechanical restraints are used only as a prevention against self-injury, injury to others or property damage. (Refer to key indicator for additional requirements.)** **Non-Performance**

None of the three documented incidents of the use of mechanical restraints included all the required elements. One included a PAR Report and logbook entry, but lacked circulation checks, supervisory interviews, and the time of application and removal of restraints. Another application of restraints did not include the reasons for application, person approving, and notation in the logbook, person applying the restraints, or verbal efforts to de-escalate the need for restraints. A third application (youth reported) was not supported by any documentation.

**6.10 Written policy, procedure and practice document that the use and type of countermoves, control techniques, or pressure points are used as a last resort, following the "Protective Action Response Escalation" matrix. (Refer to key indicator for additional requirements.)** **Partial**

**P** The written policy and procedure address all areas of the indicator. Reports included verbal interventions. Of 30 Protective Action Response (PAR) reports reviewed, none were documented in the program logbook.

**6.11 Written policy, procedure and practice document that a PAR report is completed anytime staff use countermoves, control techniques, takedowns, pressure points or the application of mechanical restraints, including a restraint chair. (Refer to key indicator for additional requirements.)** **Partial**

The written policy and procedure address all areas of the indicator. According to the policy, the facility administrator will review the PAR report after all other reviews. In practice, it is the assistant facility administrator who conducts the final review. Thirty PAR reports were reviewed for compliance with the key indicator. Reports appear to be completed by the end of shift. In a review of the incident narratives, four did not specify the type of technique(s) utilized by staff. Required parties reviewed nine of the thirty reports within 72 hours as indicated by dated signature. In the remaining reports: three had no lead staff signature; two were not signed by the supervisor; three were not signed by medical staff; twelve either were

not signed by PAR staff or the signature was not dated to indicate when it was signed; and seven were not signed by the facility administrator/designee or the signature was not dated to indicate when it was signed. In addition, there was no corresponding PAR report for an instance in which mechanical restraints were used; only the breathing and circulation log was available for review.

**External Control Factors**

None.

## STANDARD SEVEN: FOOD SERVICES

**Overview:**

The provider contracts with a catering company to provide dinner daily and breakfast and lunch when school is not in session. The county school system, using two different schools (one middle school and one high school) provides breakfast and lunch to the program when school is in session. The program kitchen facility is adjacent to the dining area, consists of commercial refrigeration and freezer units, a minor food preparation table and a steam table serving unit. Direct care staff pick up meals from the food service provider, assemble the final meal at the facility and serve the meal to youth. Some portions of the school provided meals were packaged for each youth, with the remainder provided in bulk, requiring staff to apportion to each youth. The program determined the school provided lunch menu was lacking enough caloric content consistently and has supplemented it with a sandwich from the caterer.

**7.01 Food service areas are inspected at required intervals by the county environmental heath unit: 0-10 beds - no inspection needed, 11-24 beds - 1 time annually, 25 or more beds - 4 times annually. All heath violations noted on the inspection report have been corrected or there are plans in place to correct them.** **Full Compliance**

**C/P**

**7.02 There is documentation that the program's system of dietary allowance is reviewed annually and approved by a registered dietitian to ensure youth are provided a nutritionally adequate diet. The annual review and approval certifies that the menu incorporates and complies with Dietary Guidelines for Americans, Recommended Dietary Allowances and the food guide pyramid published by the National Center for Nutrition and Dietetics. (Refer to the key indicator for additional requirements.)** **Non-Compliance**

**C/P** The county school system provides breakfast and lunch to the program on the days that the school is in session. The program also has the catering company provide meals and snacks each day. The school system has menus that are posted with a variety of choices for each day for breakfast and lunch. The program did not appear to know in advance which items the youth would be served each day. If the catering service reviewed the school menus, it did not appear they were coordinated with each other to maintain a balanced diet. On Tuesday of the review week, the team observed that youth had tacos for lunch and the meal consisted of rice, salad, taco shell, cake, a beef mix and a sandwich which the caterer provided. Dinner on Tuesday consisted of rice, salad, roll and a bean and beef mix. On Wednesday, youth were served pizza for breakfast and pizza for dinner. None of the menus reviewed had any caloric counts listed.

**7.03 Written policy, procedure and practice require that food service staff develop advanced, planned menus; document that planned menus substantially follow the schedule; and plan/prepare meals taking into consideration the food flavor, texture, temperature, appearance, and palatability.** **Partial**

The contracted food service providers did not appear to have coordinated the menus or

developed advanced planned menus. Production records were unavailable for review to determine if meals followed the scheduled menu. Interviews with the youth revealed that they think the new catering company's food is good. Observations of meals served during the review revealed that they smelled good and were palatable. Lunch meals were picked up around 11:00 am. The schedule had lunch groups starting at 11:30 am and the last group starting lunch at 12:45 pm, thus an extended period between delivery and serving. Insulated bags appeared to keep the food warm, but not hot. Of the 19 youth surveyed eight said the food was good and three said excellent. Of the 11 staff surveyed, four rated the food good and two said excellent.

**7.04 Written policy, procedure, and practice provide for special diets as prescribed by appropriate medical or dental personnel or for youth whose religious beliefs require adherence to religious dietary laws.** **Non-Compliance**

**C** The nursing staff provides the kitchen staff a sheet that has the youth's picture on it and the food allergies as well as any restrictions in diet. The school does not send over any special diet meals and observation of the evening meal had no special food provided. Interviews with the youth revealed that staff does provide them a sandwich of either peanut butter or a hot dog in place of the main food item they could not eat. One youth with lactose intolerance was served milk at breakfast and allowed to trade with other youth for food they did not want. Of the 19 youth surveyed, nine youth said that substitutions are sometimes done and one said no they are not. Of the 11 staff surveyed, all indicated that they are aware of special diets.

**7.05 Written policy, procedure, and practice require that at least three meals, one of which is a hot meal, are provided at regular meal times during each 24-hour period. There shall be no more than 14 hours between the evening meal and breakfast. (Exceptions are acceptable on weekend and holidays where youth are allowed to sleep later and brunch is served.) At least one snack per day is provided.** **Non-Performance**

A review of the posted schedule and observation revealed that there is more than 14 hours between dinner and breakfast. Breakfast is served to all youth in their unit day room, not in the cafeteria because of the time constraints of getting the meals from the school, serving the youth at 8:25 am and having them ready for school by 9:00 am. Youth were observed eating breakfast, sitting on the couches and on the floor holding the trays provided from the school system. A nutritional snack is provided daily.

**7.06 Written policy, procedure, and practice document that an Individual Determination Form is completed for each youth admitted.** **NA**

**C/P** The provider does not participate in the National School Lunch program. The county school system receives the National School Lunch and Breakfast funds and provides the program breakfast and lunch during the school year. This indicator was not rated for the provider.

**7.07 Written policy, procedure, and practice document that food service personnel document the number of meals served to youth at breakfast and lunch through a formal, approved meal count. (Refer to the key indicator for additional requirements.)** **NA**

**C/P** This indicator is not rated because the provider does not receive National School Lunch funds.

**7.08 The kitchen and dining area are clean and well maintained.** **Satisfactory**

The kitchen area and dining area were observed to be clean. During the walk thru it was noted that the dining area had holes in the walls. The repairs to the dining area were completed during the week. Maintenance and sanitation reports were maintained.

**7.09 Written policy, procedure, and practice document that the program's designated food service manager has a Food Service Manager's Certificate. If there are four or more** **Full Compliance**

**employees at one time engaged in the preparation and serving of food, the certified manager must be present at all times.**

**C**

**7.10 Written policy, procedure and practice document that kitchen equipment and eating utensils must be inventoried and kept in a secure location. (Refer to the key indicator for additional requirements.)** **Full Compliance**

**C**

**External Control Factors**

None.

## STANDARD EIGHT: HEALTH SERVICES

**Overview:**

The program employees one registered nurse (RN) and two licensed practical nurses (LPN) as well as using a nursing service to provide care seven days a week from 8 am to 11 pm. Due to the turnover in staff, the program is in the process of hiring additional nursing staff so that they can discontinue the use of the nursing service. The program has a contract with an Advanced Registered Nurse Practitioner (ARNP) and Physician to provide services at least one day a week on site. The program has an agreement with a dentist to provide care to the youth. An optometrist provides on-site care to youth.

**8.01 Written policy, procedure and practice document that all youth who are admitted to the program are screened for health related conditions at the point of entry using the Facility Entry Physical Health Screening form. The Designated Health Authority is notified if the Facility Entry Physical Health screening or other information in the file indicate the youth has any of the indicated conditions. (Refer to the key indicator for additional requirements.)** **Satisfactory**

**P** Written policy and procedure do not address the re-screening requirements when physical custody of the youth changes. Health Admission Screening Assessments occur upon intake as well as anytime physical custody changes. A review of 20 files revealed that all 20 files contained the Health Admission Screening completed on the day the youth was admitted. Three of four applicable files documented a re-screening when required. Two applicable files reviewed requiring designated health authority notification because a youth had been admitted with an indicated condition did not contain documentation the notification was made.

**8.02 Combined with 8.01** **NA**

**8.03 The program has a contract with a Florida licensed physician or osteopathic physician who is responsible for the oversight of healthcare. The contract includes the number of on-site hours, services to be provided, extent of availability of emergency services and specific on-call responsibilities, and specification of other duties, as agreed upon by the program and the designated health authority.** **Full Compliance**

**C**

**8.04 The program has individual healthcare operational and procedures that are reviewed and approved by the designated health authority or designee before being implemented and annually thereafter. (Refer to the key indicator for additional requirements.)** **Full Compliance**

**C**

**8.05 Written healthcare procedures and practice document that all youth admitted receive and/or have on file a current Comprehensive Physical Assessment and Health Related History prior to any participation in sports, strenuous exercise, or any other strenuous activity. (Refer to the key indicator for additional requirements.)** **Satisfactory**

Twenty files were reviewed and only one file did not have a comprehensive physical assessment completed within the required timeframe. Three of the 20 files reviewed had no documentation indicating the nursing staff had reviewed the Health Related Histories. The program schedules a new comprehensive physical assessment for all youth entering the program.

**8.06 Written healthcare procedures and practices for immunization document a system is in place in which staff are provided a school printout of all youth who attend school in the county where the program is sited as a means to verify immunizations and/or there is a system in place to obtain a history of the youth's immunizations from schools, physicians, and county public health units. This system must clearly reflect an emphasis on obtaining records. (Refer to the key indicator for additional requirements.)** **Satisfactory**

All twenty files reviewed contained a current immunization record. Documentation was found in one file requesting information in July 2004 from a parent about her son's missing immunization record; the immunization record was received on October 28, 2004. One file contained documentation of contact with a Juvenile Probation Officer (JPO) requesting information about the youth's immunization. The nursing staff documents in the youth's file when immunizations are required. The nursing staff document attempts to get verbal consents and the mailing of the Parental Notification of Health Related Care Vaccination/Immunization Form when the youth is in need of any immunizations.

**8.07 Written healthcare procedures and practices document a system is in place that ensures determination of the actual medication regimen of the youth upon admission which includes a procedure for timely notification of prescribers of medication upon admission, verification of the authenticity of prescribed medication brought with the youth to the program, prescribed medications are purchased and procured in a timely manner and there is an established mechanism through which medications are paid for at the facility.** **Full Compliance**

**C**

**8.08 Written healthcare procedures and practice regarding the safe and secure storage of medications must document all medications are stored in a separate, secure (locked) area which is inaccessible to youth (when unaccompanied by an authorized staff member.) (Refer to key indicator for additional requirements.)** **Satisfactory**

Medications are secured under a double lock system and are inaccessible to youth. Oral, topical and injectable medications are stored separately. A perpetual inventory is maintained for all narcotics/controlled substances. There was no evidence that shift-to-shift inventories and counts occur consistently. Syringes and sharps are only inventoried monthly. Over-the-counter medications are administered as needed for a youth and recorded through a perpetual inventory. The program has a form that is completed when medications are returned to the pharmacy for credit. The form lacks a place for the signature of the person accepting the returned medications at the time of pickup for the pharmacy. Procedures for medication administration included flushing of the medication if a youth refused it; however, no documentation was completed nor was the disposal witnessed. No form was completed or witnessed for the disposal of a narcotic or controlled substance.

**8.09 Written healthcare procedures and practices document a system of medication administration that ensures the safe and effective provision of medication. (Refer to the key indicator for additional requirements.)** **Satisfactory**

Twenty files were reviewed and 11 of the files were applicable to this indicator. All 11 files revealed that the youth received their medication as prescribed. Each dosage of medication was documented on the Medication Administration Record (MAR) or a note was found that indicated why the youth did not take the medication. Observation of the medication being administered revealed that the nursing staff are not in the habit of opening the MAR and recording on it at the time they administer the medication. The program's MAR forms do not contain information about side effects. The side effect sheet is kept behind the MAR. Allergies were noted on the MAR except in two of the youth files. The nursing staff communicates through the use of a logbook used by the nursing staff that contains information about the youth so that each shift is informed of any medical issues.

**8.10 Written healthcare procedures and practices document that if the program operates a modified class II pharmacy, the program has a Florida permit to operate a modified class II pharmacy. (Refer to the key indicator for additional requirements.)** **NA**

**C** The program does not operate a Modified Class II Pharmacy; therefore, this indicator was not rated.

**8.11 Written healthcare procedures and practice provide that all youth receiving prescription medications are monitored on an on-going basis for side effects. Youth on psychotropic medications and/or anti-tuberculosis medications must have <u>specific documentation</u> of on going monitoring for side effects by healthcare staff if on-site. (Refer to the key indicator for additional requirements.)** **Partial**

A review of 20 youth files and interviews with nursing staff revealed that anti-tuberculosis medication in two of the files reviewed were not being monitored weekly during the first month and monthly thereafter as required. Further, youth on psychotropic medications did not have weekly documentation of monitoring for side effects. Observation of medication administration by nursing staff revealed that they are speaking with the youth and ask how they feel. If the youth complains of problems with eating, sleeping and being tried or anxious, the information is not being documented as required. Psychotropic medication appointments are documented monthly and contain all of the required elements of the indicator.

**8.12 Written healthcare procedures and practice document a "medical and mental health alert" system is in place that ensures information concerning a youth's medical and/or mental health condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent treatment information is communicated to staff. (Refer to the key indicator for additional requirements.)** **Satisfactory**

**P** The program has a medical and mental health alert process. The nursing staff provides information to the food service staff using picture identification along with the listed allergies or special diet needs of a youth. The program has on each unit a logbook that contains information concerning a youth's medical, mental health, food, and other allergies. Interviews with the nursing staff revealed that for two months this information was not kept up to date on the units. There was limited documentation in the unit logs concerning medical/mental health alerts. Of the 11 staff surveyed, all responded that there is a medical/mental health alert system in place. Six of the staff surveyed also responded that they are informed of side effects of medication.

**8.13 Written healthcare procedures and practice for episodic care (first aid and emergency care) documents basic procedures for on-site first aid care (including dental trauma), a posted readily available list of emergency telephone numbers including, but not limited to Emergency Medical Services (EMS), and Poison Control. (Refer to the key indicator for additional requirements.)** **Satisfactory**

**P** The program has basic procedures for on-site first aid care including dental trauma in place for all staff to follow. Emergency telephone numbers are posted. The program has designated

a hospital for emergency care. The program has conducted only two medical emergency drills beginning in May 2004. Two of 11 staff surveyed indicated they have participated in a mock medical emergency drill. Eight of the 11 staff surveyed responded that it requires supervisory approval to call 911.

**8.14 Written healthcare procedures and practices document that a system is in place, which provides for control of infectious, communicable diseases. (Refer to the key indicator for additional requirements.)** **Full Compliance**

**C**

**8.15 Written healthcare procedures and practice document that a system is in place, which provides for the provision of sick call care. Minimum frequency of regularly scheduled sick call is 10-25 beds - 2 x weekly, 26-50 beds - 3 x weekly, 51 + beds - 5 x weekly. (Refer to the key indicator for additional requirements.)** **Satisfactory**

Sick call is regularly scheduled seven days a week and is provided by the nursing staff. Sick call forms could not always be matched to the notes or sick call index. Interviews with the youth and observation of sick call confirm that the form was not always being completed. A dentist is available to see the youth by appointment for dental complaints except for emergencies. The youth are scheduled to seen by an optometrist at the facility. The ARNP or the doctor address all health related issues during their weekly on-site visits. Seven of the 19 youth surveyed said they could see the nurse immediately and five said within one day. All youth surveyed reported that they get to see a doctor. Of those youth responding to the survey, six said they were able to see a dentist and the other 12 said they have not had a toothache. Five of the 11 staff surveyed responded that sick call is held as needed and two said once a day. Nine of the 19 youth surveyed rated the medical services excellent and seven rated it good.

**8.16 Written healthcare procedures and practice specify a system is in place to address HIV, which provides confidential HIV testing. (Refer to the key indicator for additional requirements.)** **Satisfactory**

Written policy and procedure address all the elements of the indicator. The county health department is scheduled to provide testing to the youth as well as pre- and post-test counseling. Youth were given the chance to sign up to be tested. Of the 19 youth surveyed, 12 responded that they can be tested.

**8.17 Written healthcare procedures, and practices provide that general parental authorization for healthcare is obtained and parents are notified of healthcare. (Refer to the key indicator for additional requirements.)** **Satisfactory**

All 20 files reviewed contained the Authority for Evaluation and Treatment Form. Three of the forms were not originals but were copies and there was no attempt to obtain an original signature. Eleven of the files contained documentation of either a verbal consent for medication and/or of sending the written Parental Notification Form. One of the files contained the written notification form signed and returned by the parent.

**8.18 In facilities housing females, written policy and procedure document that a comprehensive system for providing primary, obstetrical, and gynecological services is in place.** **NA**

**C** This is a male only program; therefore, the indicator was not rated.

**8.19 Written healthcare procedures and practice document that health education is provided to all youth. Specific topics to be delivered must include, but not be limited to, prevention of communicable diseases, AIDS education for all youth and general information on prevention of alcohol, nicotine products and substance abuse. Health** **Satisfactory**

**Education is documented on the DJJ Health Education Record.**

Health education is being provided at intake, which is documented on the Health Education Record. The nurse records health education on medication prescribed or injuries. The nurse has provided and documented a limited amount of health education during each youth's stay.

**8.20 Written healthcare procedures and practice regarding health records document that the healthcare record is physically separate and distinct from the individual management record. (Refer to the key indicator for additional requirements.)** **Satisfactory**

**P** Twenty files were reviewed and all were consistently well organized. One file not marked confidential the first day of the review was stamped confidential during the week. Health records are maintained in a locked office in the medical area. An interview with the nursing staff revealed neither closed medical files nor any of the mental health records have been sent back to the JPO. Observation of the medical storage area confirmed the practice. The staff stated that when a youth is transferred, the medical record was sent with him.

**8.21 Health Services Report. Deleted.** **NA**

**8.22 HIPAA. Deleted** **NA**

**External Control Factors**

None.

## STANDARD NINE: PROGRAM SECURITY

**Overview:**

The program is a Level 6, Moderate Risk, staff secure facility with a temporary population capacity of 80 youth. The AFA, shift supervisors and unit managers are primarily responsible for security. The program operates a master control under the authority of the shift supervisor that coordinates all youth movement, checks visitors in and out, and maintains key control and campus security.

**9.01 Written facility operating procedures outline procedures to be followed when additional coverage is needed. The procedure ensures there is always at least one staff of the same gender as the youth on duty, staff schedule is provided to staff or posted in a place visible to staff and there is a holdover or overtime rotation roster which includes the home telephone numbers of staff who may be accessed when additional coverage is needed.** **Satisfactory**

The written procedures address all areas of the indicator. Procedures include that all employees have two "blue-dot" days per week which are annotated on the schedules by highlighting and coloring in the box for that shift on that day. Procedures also include using a staff phone list and requesting on-duty staff to acquire volunteers to work a double to cover unexpected vacancies prior to using the blue dot designated staff. All shifts reviewed contained the required staff coverage and at least one staff of the same gender as the youth.

**9.02 Written policy, procedure and practice document the program establishes and maintains recommended staffing ratios. (Refer to the key indicator for special requirements by program model.)** **Partial**

The written procedures address all areas of the indicator. A review of previous and current week's staffing pattern documentation revealed ratios in accordance with the indicator. Additional staff were scheduled during the review week to monitor youth on precautions.

However, team members observed several times during the week youth-to-staff ratios not in compliance during selected activities. In addition, on one occasion, 10 youth were observed in the common area of a unit with no staff present and two staff monitoring 27 youth. Previous monitoring reports documented failures to maintain staffing ratios in accordance with the indicator as well as youth being supervised in spaces unauthorized for youth.

**9.03 Written policy, procedure and practice govern the control and use of keys. (Refer to the key indicator for additional requirements.)** **Partial**

The designated key control officer was unfamiliar with the policy. All personnel interviewed as responsible for key boxes in master control have a good concept of key control. All master control key boxes contained key hooks and key ring tags with the number of keys on each ring being in consonance with the tag. However, in two other boxes (AFA office and maintenance), the key ring reference file was not accurate. Each key did not have a control code. Restricted keys were not clearly separated. Key ring tags for permanent issue keys did not consistently reflect the number of keys on the ring. No master key inventory was found. Personal keys were found on one permanent issue key ring. The team observed one staff hand their permanent issued keys to another staff.

**9.04 Written policy, procedure and practice require that the program maintain a permanent, bound logbook to record routine information, emergency situations and incidents. (Refer to the key indicator for additional requirements.)** **Partial**

Logbooks did not consistently highlight items of safety and security. Logbooks were missing hours and days. Staff did not consistently document occurrences during school hours (from 9:00 am to 2:00 pm) and after 11:00 pm. Oncoming supervisory reviews were not consistently documented. Administrative weekly reviews were not consistently documented except within the last six weeks.

**9.05 The program has a system for physically counting juveniles. The system allows for managing the movement of and identifying the specific location of each youth at all times. (Refer to the key indicator for additional requirements.)** **Satisfactory**

The written policy and procedure address all areas of the indicator. Procedures define four different types of required formal counts and times to conduct emergency counts, including site-specific conditions. The team observed staff coordinating counts with master control prior to beginning movement and prior to entering spaces. The team observed some instances in which youth were not in the direct line of sight of staff.

**9.06 Written policy, procedure and practice document security checks are conducted daily on each shift and documented in the program logbook. (Refer to the key indicator for additional requirements.)** **Satisfactory**

The written policy and procedure address all areas of the indicator. The program does not have any video security camera equipment. Staff stated they had not found any contraband during their searches or perimeter checks. The team observed numerous items of contraband near the perimeter of the program that appeared to have been there for some time. The team observed a perimeter check that included primarily checks of all exterior doors and windows.

**9.07 Security lighting is provided around the outside perimeter of the program and all other areas. Security lighting is provided around administrative buildings and common areas in wilderness programs.** **Full Compliance**

**C**

**9.08 Written policy, procedure and practice document that the program has an escape prevention and response plan that ensures swift action by staff and required notifications are made. (Refer to the key indicator for additional requirements.)** **Satisfactory**

**P** The written policy and procedure address all areas of the indicator. The Department signed the plan in March 2004. The plan provides guidance for all areas of the indicator. The plan does not address the role of overlay personnel who are included in staff ratios in case of an escape attempt. The escape log presented to the review team was a bound logbook. Following the escape in February 2004, the program took most of the steps outlined in the plan, even though it had not yet been approved.

**9.09 There have been no escapes from the program since the last QA review.** **Non-Compliance**

**C** An escape occurred on February 16, 2004.

**9.10 Written policy, procedure, and practice address program and room searches for contraband. The facility operating procedure outlines the procedures for searches of common areas before and after use by youth and youth who return from off-campus trips and home visits according to Department standards and Contract requirements. (Refer to key indicator for additional requirements.)** **Satisfactory**

The written policy and procedure address all areas of the indicator. The program staff state that searches are documented during management's daily shift walk-through inspection. During the team's tour, trash was observed in several youth lockers unassigned to a program youth. Gangster rap writing was found under cushions in common areas. Staff said it was common practice for youth to leave items under the cushions. Searches of common areas prior to and following visitation and other program activities was not found documented. Numerous frisk searches were observed following movement from outside activities. Frisk search methods observed were not consistent and were cursory. Youth surveys state that searches happen often. The program stated they have not uncovered any contraband during searches.

**9.11 Written policy, procedure and practice regarding security of vehicles document all program vehicles are locked when not in use, keys to program vehicles are stored in a secure locked box provided for the storage of keys. Keys to house parents vehicles are kept in a secure location and not accessible to youth.** **Substantial Compliance**

**C** The written policy and procedure address all areas of the indicator. The keys to the vehicles were observed stored in master control in a locked box. One vehicle was found unsecured on Wednesday of the review.

**9.12 Moved to the Food Services Standard, Key Indicator 7.10** **NA**

**9.13 Moved to the Behavior Management Standard, Key Indicator 6.09** **NA**

**9.14 Written policy, procedure and practice for the use of mechanical restraints document a written inventory is maintained of all mechanical restraints kept in the facility and access to restraining devices is limited to staff who are designated by the superintendent. (Refer to the key indicator for additional requirements.)** **Non-Compliance**

**C** Mechanical restraint inventories presented did not include all program mechanical restraints. One of the areas in which mechanical restraints were maintained was not consistently secure during the review, thus any staff could have had access to the restraints. Staff stated that one inventory was signed by another person in his name for a date on which he was not employed by the program.

**9.15 Moved to the Behavior Management Standard, Key Indicator 6.10** **NA**

**9.16 Written policy, procedure and practice document that staff visually checks the safety and security of each youth at least every 10 minutes anytime youth are placed in their sleeping rooms (including rest periods). Written documentation of room checks is maintained on-site and forms used for documentation do not have pre-printed times.** **Non-Compliance**

**C** The written policy and procedure address all areas of the indicator. A review of the practice of 10-minute checks found some staff pre-printing the times of the checks. In addition, some staff were observed posting on one occasion several consecutive 10-minute checks.

**9.17 Written policy, procedure and practice document that the program has a comprehensive plan for transportation of youth and the use of restraints during transports. (Refer to key indicator for additional requirements.)** **Satisfactory**

The written policy and procedure address all areas of the indicator. One transportation event was observed during the week. The process followed the written procedure. A search of the vehicle was observed prior to the transport and following the event. The program performs a modified strip search in which youth remove all clothing except for underwear following transports. One staff and the review team member were present during the search.

**9.18 Combined with key indicator 3.01** **NA**

**9.19 Written policy, procedure and practice document that the program maintains strict control of tools. (Refer to key indicator for additional requirements.)** **Satisfactory**

The written policy and procedure address all areas of the indicator. The maintenance director is the designated program safety coordinator. Staff stated that youth do not work with Class "A" tools or with the maintenance personnel. However, one staff was designated to spray paint buildings and youth were allowed to assist in the project over the past few months. The program, in conjunction with a building trades vocational program (HBI) was observed working with tools. Staff-to-youth ratios were maintained using the vocational program staff. Daily Class "A" tool inventories were observed completed with a few omissions. Monthly class "B" tool inventories were incomplete. Class "B" tool checkout documentation consistently included a general notation that all tools were checked out.

**9.20 Written policy, procedure and practice document the program has a written plan dealing with riots and disturbances. The plan has been reviewed and approved by the DJJ Regional Director or designee. (Refer to key indicator for additional requirements.)** **Full Compliance**

**C**

**External Control Factors**

None.

## STANDARD TEN: PROGRAM SAFETY AND EMERGENCY PROCEDURES

**Overview:**

The shift supervisor and or unit manager is responsible for the cleanliness and safety review. The maintenance supervisor is responsible for general maintenance. The site management is responsible for large equipment maintenance and repair. Direct care staff are responsible for keeping the unit first aid kits fully stocked through nursing services. An overlay vocational program co-located in one of the units is providing repair/replacement training and construction activities.

**10.01 Written policy, procedure and practice document weekly safety and preventative maintenance inspections to ensure the program remains safe, clean and in good repair. Weekly preventative maintenance inspections include checking emergency generators, fire safety equipment, communication equipment (weather radio, walkie-talkie, etc.) and any other safety related equipment or supplies needed in an emergency or to prevent injury to staff or youth. (Refer to key indicator for additional requirements.)** **Partial**

The written policy and procedure address all areas of the indicator. A weekly preventive maintenance schedule was not in place for heating, ventilation, air conditioning equipment, refrigerators or freezers. The site management stated they had done preventive maintenance and follow-up maintenance on the air handling systems since July 2004. The weekly safety inspection covers youth living area only, not other internal and external areas. Preventive maintenance began on fire safety equipment and the emergency generator in June 2004. Procedures and practice were in place to provide for pest control and garbage removal.

**10.02 The program has a Continuity of Operations Plan (COOP) that ensures the continuity of mission essential functions when an emergency event prevents occupancy of the primary program site. The plan is approved and signed by the program director and Regional Director for Residential and Correctional Facilities.** **Full Compliance**

**C/P**

**10.03 Deleted. This is part of key indicator 10.04.** **NA**

**10.04 The program has a fire prevention program that is approved by the local fire official. (Refer to the key indicator for additional requirements.)** **Partial**

**P** There was not a fire safety log in place and no documentation to show that drills were being conducted prior to May 11, 2004. Since that time, drills were documented monthly on all three shifts. The fire prevention plan is not signed by the local fire official, although the program received a letter from the local fire chief stating the program address was in their area of coverage and they would provide emergency services. This letter was considered sufficient by the Department at the pre-opening inspection. Egress plans were posted in prominent places. Staff received fire safety training according to the indicator.

**10.05 Written policy, procedure and practice document that the program maintains strict control of flammable, poisonous and toxic items. Inventories are maintained of all flammable, poisonous and toxic fluids used in each facility. (Refer to key indicator for additional requirements.)** **Partial**

The written policy and procedure address all areas of the indicator. Items from the inventories of all flammable, toxic, and poisonous materials appear to be drawn by authorized employees only. Material Safety Data Sheets (MSDS) were accurate, up to date and well maintained. Although there is an approved procedure in place, disposal of hazardous chemicals was not done in accordance with prescribed regulations prior to the review week.

**10.06 Written policy, procedure and practice document an annual safety inspection is conducted by a certified mechanic, the Florida Highway Patrol or other law enforcement agency on all vehicles that transport youth to ensure the tires, lights and brakes are safe. Vehicles that transport youth are equipped with a first aid kit, a fire extinguisher, and seat belts securely anchored. Documentation of completion of safety repairs is present. (Refer to key indicator for additional requirements.)** **Full Compliance**

**C** The written policy and procedure address all areas of the indicator. All vehicles had up-to-date annual inspections, fire extinguisher, fully stocked first aid kit and seatbelts.

**10.07 Written policy, procedure and practice provide that first aid equipment and supplies are approved by the designated health authority or designee and is available at all times including first aid kits that are in designated areas of the program. There must be at least one first aid kit that is easily accessible to staff. There will be a "knife for life" and small wire cutters maintained on a shadow board in a secure area accessible to staff in the event a youth attempts suicide. (Refer to key indicator for additional requirements.)** **Full Compliance**

**C/P**

**10.08 Written policy, procedure and practice document that if the program offers open water activities, including swimming and boating, all youth and staff participating must be swim tested and demonstrate swimming skills. (Refer to key indicator for additional requirements.)** **NA**

**C** The program does not practice open water activities; therefore, the indicator was not rated.

**10.09 Written policy, procedure and practice document that if the program offers aquatic activities at swimming facilities such as swimming pools or water theme parks, it provides guidelines to include a certified lifeguard being present during any aquatic activities. (Refer to the key indicator for additional requirements.)** **NA**

**C** The program does not practice activities at swimming facilities; therefore, the indicator was not rated.

**10.10 Written policy, procedure and practice address the prevention of heat stress injuries through adherence to accepted heat stress and exercise tolerance guidelines. (Refer to key indicator for additional requirements.)** **Satisfactory**

The written policy and procedure address all areas of the indicator. Youth have access to water fountains in the courtyard during outside recreation. All staff were current in their first aid training.

**External Control Factors**

The program was unable to get the local fire department to approve the facility fire prevention plan.

## STANDARD ELEVEN: TRANSITIONAL RELEASE PLANNING

**Overview:**

The case managers are responsible for transition planning activities. Pre-release notifications and summaries are prepared by the case managers and sent to the youth's JPOs. Case managers are also responsible for the closed files and sending the packets to the youth's assigned JPO upon release from the program.

**11.01 Written policy, procedure and practice document that a youth's conditional release date is determined by the treatment team based upon the youth's successful completion of their performance plan. (Refer to key indicator for additional requirements.)** **Partial**

**P** The written policy and procedure address all areas of the indicator. Procedures include that once a youth obtains level four, the multidisciplinary treatment team will decide if the youth is ready to start the transition process, as evidenced by completion of the first four performance plan goals and satisfactory performance on any individual performance goal. The youth's length of stay cannot be extended due to a sanction or punishment. The length of stay may be extended if the youth fails to comply with or participate in treatment activities. Ten cases were reviewed for this key indicator. It was difficult to determine if a youth's release date was determined based upon the successful completion of his performance plan goals, as the plans did not consistently document if the goals had been completed. Each

performance plan documented two or three goals. In two of these cases, the last performance summary report, completed prior to discharge, noted unsatisfactory school performance and behavior problems. One youth had his release date extended and one youth did not. The youth that did not have his release extended documented in his progress notes placement in ISS, uncontrollable behavior resulting in being restrained by staff and suggestion by the assigned juvenile probation officer that the youth be extended. Neither case documented a change or revision to the performance plan goals.

**11.02 Written policy, procedure and practice document that the program contacts the conditional release counselor or post commitment probation officer 60 days prior to release (90 days if the youth is committed for a sex offense) to develop a joint written transition plan. (Refer to key indicator for additional requirements.)** **Partial**

**P** The written policy and procedure address all areas of the indicator. The transition plan is categorized into ten sections including: educational status, mental health status, medical status, family status, court sanctions/conditional release requirements, employment, life skills, and needs/goals to be completed upon return to community. Ten files were reviewed for transitional planning. Contact with the assigned JPO or conditional release counselor 60 days prior to release was documented in five of ten files, as evidenced by the transition plan or progress notes. Nine of ten files contained a transition plan; however, one plan was blank except for the youth and case manager's dated signature. Another plan was not signed or dated. Seven files documented a completed transition plan prior to the exit conference. The transition plans contained limited information, often leaving blank sections. Only one plan recorded life skills information, only two plans included ongoing mental health or medical or substance abuse needs, and only six plans identified needs or goals to be completed upon return to the community. Parental involvement was only noted in four files and education involvement was documented in six files. One file reviewed involved a youth jointly served by DJJ and the Department of Children and Families (DCF) and there was no documentation the program notified or involved DCF in the transition planning and exit conference.

**11.03 Written operational procedures and practice document that prior to conditional release from the program, the program makes required notifications to the juvenile probation officer, educational staff, parents/guardians, victim and commitment manager. For youth jointly served by DJJ and DCF, the DCF Counselor is notified 30 days in advance of a youth's release to allow time to coordinate placement with an appropriate placement. (Refer to key indicator for additional requirements.)** **Partial**

The written policy and procedure address most areas of the indicator. Notification of the DCF family services counselor 30 days in advance of a youth's release to allow time to coordinate placement with an appropriate caregiver was not addressed. Ten files were reviewed for this key indicator. In one case the youth was in the custody of the Department of Children and Families and there was no coordination of release placement. In four cases, there was no release summary completed and one file did not have a copy of the pre-release notification to determine when it was sent. In the nine files containing a pre-release notification, it was sent at least 45 days in advance in seven cases. Of the six files containing a release summary, none were sent 45 days prior to release.

**11.04 Written policy, procedure and practice document that not less than 14 days prior to release, but after the pre-release notification, an exit conference is held at the program to coordinate release procedures and prepare the youth for conditional release supervision or direct discharge. (Refer to key indicator for additional requirements.)** **Partial**

The written policy and procedure address all areas of the indicator. Ten files were reviewed for compliance with the key indicator. The exit conference was conducted not less than 14 days prior to release in only four cases. One case did not document an exit conference; two were conducted three days prior to release; one was eight days prior; one was nine days prior; and one was ten days prior to release. The youth, case manager and juvenile probation officer

or conditional release counselor attended nine of the exit conferences and the parent participated in three exit conferences.

**11.05 Upon release, direct discharge or transfer the program must maintain, at a minimum, a copy of youth's admission card, release, transfer or discharge summary and transition plan, pre-release notification and acknowledgement form and transition planning documentation which includes chronological records, invitation letters to parents, education, performance plans, needs assessments and transition planning meetings.** **Substantial Compliance**

**C** Written policy covers all elements of the key indicator with the exception of maintaining a copy of the youth's transition plan. Nine closed files were reviewed for required documents. Each contained a copy of the youth's admission card, transition plan and transition planning documentation. One file did not contain a pre-release notification and four did not contain a release performance summary.

**11.06 Written policy, procedure and practice document that upon release a copy of the official DJJ youth case record, healthcare record and Education Portfolio is sent to the youth's DJJ JPO within five (5) working days as to not interrupt the delivery of services to the youth and his family. (Refer to key indicator for additional requirements.)** **Non-Performance**

Written policy in place states that the facility will send all case records to the DJJ probation officer within five working days via Federal Express and a copy of the receipt will be placed in the youth's closed file. In a review of nine closed files, two cases were sent via Federal Express within five working days of release. In the remaining seven cases, there was no documentation of the files being sent; however, the program advised the files were sent via priority mail but not return receipt. It was also determined that only the case management record and education portfolio were sent. The youth's medical file was not included and during the review it was determined that the medical file is only sent when a youth is transferred to another residential program, all other original medical files remained on site.

**11.07 Written policy, procedure and practice document the program makes required release notifications for youth who are Jimmy Ryce eligible.** **Satisfactory**

The written policy and procedure address all areas of the indicator. None of the cases reviewed were applicable to Jimmy Ryce release requirements.

**External Control Factors**

None.

## STANDARD TWELVE: TRAINING AND STAFF DEVELOPMENT

### Overview:

The program has been in operation for approximately ten months. A training coordinator was hired May 10, 2004, and developed the training program by June. The training coordinator is also responsible for quality assurance compliance. The training coordinator is a certified PAR instructor and is responsible for tracking and ensuring staff receives all required training. The training coordinator recently became a certified CPR and first aid instructor and will provide this training to all program staff also. Training is offered both in house and through CSC/Youth Services International. The program recently acquired access to the Department of Juvenile Justice CORE training website and has begun utilizing it for PAR testing.

**12.01 The program has a written master training, which is reviewed and updated annually by the program director. The plan delineates minimum training requirements for all positions, specialized training for employees who perform specific functions, training requirements for part-time staff and volunteers and procedures to incorporate training mandated by the Department.** **Satisfactory**

The program has an annual training plan. The plan outlines training requirements for new hires, full and part-time staff, and volunteers. Training topics for employees who perform specific functions (i.e. mental health, case management, maintenance and administrative staff) are also included. However, the plan does not include provisions for medical staff or for staff who perform food service duties. The facility administrator and program trainer have been identified as persons responsible for keeping abreast of new Departmental policies and training requirements.

**12.02 Written training records document that all employees and volunteers complete orientation training within the first 14 calendar days of employment. (Refer to key indicator for additional requirements.)** **Partial**

Twenty training files were reviewed for required orientation training within the first fourteen days of employment. Five employees completed program orientation within the first fourteen days of employment, as evident by a signed and dated statement placed in the employee file. However, three of five employees did not receive two of the required training topics: child abuse and incident reporting procedures. Eight additional employees completed orientation with all required topics covered; however, it was not accomplished within the required first fourteen days. Timeframes varied between one and nine months after date of hire. Six of these files contained a signed and dated orientation statement. The remaining seven employees received some orientation training, though the majority of required topics have not been covered. These employees are well past their first fourteen days of employment, between three and nine months since date of hire.

**12.03 Written training records document that all full-time staff that work in direct and continuing contact with youth receive 120 hours of training in their first 180 days of employment. Direct care staff are trained in CPR and First Aid.** **Partial**

Eighteen training files were applicable for this key indicator. Twelve employees have completed their first 180 days of employment with 76.5, 89.5, 96.75, 71.75, 83.25, 61.5, 79.25, 134.5, 74.15, 45.25, 92.25 and 65.25 documented training hours. Three of these staff are not currently CPR and first aid certified and another staff does not have current first aid certification. The remaining six files documented 121, 121.75, 116.5, 117.5, 162, and 81 training hours with five weeks, two weeks, five weeks, seven weeks, nine weeks and one week respectively to receive any additional training. Four of these staff do not have CPR and first aid certification and another staff's CPR certification expired in August. The training coordinator advised that CPR and first aid training is scheduled for November 13 – 25, 2004 for all staff not currently certified.

**12.04 Written training records document that all full time staff receive a minimum of 24 hours of job-related training annually. (Refer to key indicator for additional requirements.)** **NA**

This new provider does not have any staff applicable to the requirements of this key indicator; therefore, the indicator was not rated.

**12.05 The written staff training plan and training records document that all supervisors receive 24 hours of training annually. Eight of the 24 hours of the training shall include training in the areas management theory and practice, employee relations, communication skill and/or fiscal training.** **Satisfactory**

All staff, including supervisory staff, were new to their positions. The supervisory staff had completed training required for first year employees, but had yet to receive training on supervisory related topics.

**12.06 A training file is maintained on each staff person that includes documentation of training, including diplomas, certifications, re-certifications, examinations, practicum and test results.** **Satisfactory**

The program maintains a separate training file for each employee. Each file is divided into four sections. Documents were consistently filed within the sections with few exceptions, however, the documents were not always in chronological order. Sign-in sheets and rosters were not always filled out in their entirety documenting training topics, training hours or signature of the trainer.

**12.07 A syllabus or lesson plan, i.e., outlines or summary of the main points of all training initiated and delivered by program staff or community staff, is maintained at the program.** **Satisfactory**

Program or corporate staff conducts training, usually on site. The program maintains a detailed lesson plan for all pre-service/orientation training provided to new hires. However, not included is an outline of the 40-hour on-the-job training received. Other lesson plans included: CPR/first aid, Red Flags, HIV/AIDS, bloodborne pathogens, and mental health training. The program also utilizes the facility operating procedures for much training. Trainings conducted during staff meetings did not always have a corresponding outline or summary.

**12.08 Written training records document all personnel whose duties may require the use of verbal intervention techniques, physical intervention techniques and/or mechanical restraints are PAR certified. (Refer to key indicator for additional requirements.)** **Satisfactory**

Eighteen training files were reviewed for Protective Action Response (PAR) Training and certification. The program has two certified PAR instructors and training is conducted on site. Ten of the 11 applicable staff who have completed their first 180 days of employment have successfully completed the PAR certification process. The one employee completed the physical requirement in March, however, never took the written test. Four of five staff still within their first 180 days of employment successfully completed the PAR certification process. The fifth employee has completed the physical portion but has not passed the written exam. This employee has attempted the written exam on three separate occasions and only has five weeks remaining in his first 180 days of employment. The two remaining staff were previously certified in 2003; one completed the PAR update in January 2004 and the second staff is still in need of the PAR update training.

**External Control Factors**

None.

## STANDARD THIRTEEN: CONDITIONAL RELEASE PROGRAM

**Overview:**

The program does not provide conditional release services.

**13.01 Upon receipt of a case for conditional release supervision, field notes are developed by conditional release staff, in which, all contacts with each youth and all events in the case are recorded legibly. (Refer to the key indicator for additional requirements.)** **NA**

**13.02 The assigned conditional release staff makes a face-to-face contact with the youth and commitment program staff once per month if the program is within the same county or 50-mile radius outside the county. If the program is beyond that distance, telephone or written contact is conducted. The assigned conditional release staff makes monthly contacts with the youth's parents or guardians while he/she is in the commitment program.** **NA**

| | | |
|---|---|---|
| **13.03** | **Once a youth has been assigned to a conditional release program, the assigned conditional release staff must make monthly face-to-face contact with the youth and program staff when the commitment program is located within the same county or within a 50-mile radius if placed outside the county. (Refer to the key indicator for additional requirements.)** | **NA** |
| **13.04** | **The conditional release staff participates in the youth's transition planning process. The development of the transition plan should commence 60 days but no later than 45 days prior to the youth's anticipated release date or 90 days prior if the youth is a sex offender. (Refer to the key indicator for additional requirements.)** | **NA** |
| **13.05** | **During the transition plan, conditional release staff makes face-to-face contact at the youth's home with the youth and parent/guardian if the youth is on a home visit or other trial visit from a commitment program. (Refer to the key indicator for additional requirements.)** | **NA** |
| **13.06** | **The conditional release staff makes face-to-face contact with the youth within 24 hours (excluding weekends and legal holidays) of the youth's return home from the residential program. The conditional release staff explains the program goals, rules and actions for failing to comply. (Refer to the key indicator for additional requirements.)** | **NA** |
| **13.07** | **If educational services or vocational school are part of the supervision plan, the conditional release staff initiates activities with the school system within 24 hours of the youth's release from the program to assist the family in the youth's enrollment. (Refer to the key indicator for additional requirements.)** | **NA** |
| **13.08** | **Within 14 calendar days of the youth being placed on supervision, the JPO/contracted case manager develops an individualized supervision plan with the youth and parent/guardian. (Refer to the key indicator for additional requirements.)** | **NA** |
| **13.09** | **Staff review the supervision plans with the youth every 14 calendar days and with the youth *and* parent/guardian every 30 calendar days. Modifications reflect both the youth's positive and negative adjustments.** | **NA** |
| **13.10** | **The conditional release staff makes the appropriate number of contacts consistent with the youth's level of commitment. (Refer to the key indicator for additional requirements.)** | **NA** |
| **13.11** | **Written policy, procedure and practice document that if a youth needs mental health or substance abuse services, the juvenile probation officer refers the youth for services within seven working days of receipt of the comprehensive assessment. There is documentation that the JPO/contracted case manager followed-up to determine whether the youth and family attended the initial appointment.** | **NA** |

**13.12** **Written policy, procedure and practice document that the supervisor reviews each case with the assigned staff 30 calendar days after the youth is placed on conditional release supervision or assigned to the conditional release program. (Refer to the key indicator for additional requirements.)** **NA**

**13.13** **Written policy, procedure and practice provide that the conditional release staff facilitates or provides transportation assistance for the youth to and from the program, to job interviews, medical appointments, recreational activities, etc. in the home community as required.** **NA**

**13.14** **Written policy, procedure and practice document that the program has a grievance process that allows youth or parents to grieve, in writing, the actions of program staff or youth's peers, or conditions or circumstances of care and treatment. (Refer to the key indicator for additional requirements.)** **NA**

**13.15** **The program maintains a weekly schedule for conditional release supervision that indicates flexible workdays and 24 hour a day availability. Supervisors review these schedules on a routine basis (minimum monthly) to determine continued need and appropriateness.** **NA**

**13.16** **Written policy, procedure and practice provide that the conditional release staff informs the assigned DJJ Juvenile Probation Officer and the parents of all-important occurrences. (Refer to the key indicator for additional requirements.)** **NA**

**13.17** **The JPO/contracted case manager submits an affidavit or request for an Order to Take Into Custody within 72 hours to the court once it has been determined that a youth has absconded from supervision. (Refer to the key indicator for additional requirements.)** **NA**

**13.18** **Written policy, procedure and practice specify that prior to transferring a youth, the case is staffed with the supervisor and the JPO/contacted case manager notifies the youth and parent/guardian of the request to transfer by sending them copies of the performance transfer summary. (Refer to the key indicator for additional requirements.)** **NA**

**13.19** **Written policy, procedure and practice document that a youth's release date is determined by the assigned conditional release staff in collaboration with the assigned juvenile probation officer. (Refer to the key indicator for additional requirements.)** **NA**

**P**

## EDUCATIONAL SERVICES

**The education scores are inclued in excel.**